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1.0 Description of the Procedure

The terms rhinoplasty, septoplasty, and septorhinoplasty are sometimes used interchangeably, but they have distinct meanings. A *rhinoplasty* is cosmetic or reconstructive surgery done to alter the contours of the nose itself without involvement of the underlying nasal septa. A *septoplasty,* on the other hand, involves only the septum. However, in clinical practice, a surgical procedure sometimes involves elements of both a rhinoplasty and a septoplasty. This is referred to as a *septorhinoplasty,* a more extensive procedure combining repairs to the external nasal pyramid or skeleton with repairs of the nasal septa in order to correct a functional impairment involving both structures. This may involve correcting damage or functional deficits that result from disease, surgery, or trauma. The surgery may also be performed to correct a congenital defect such as a cleft lip or palate.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination****** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

a. that is unsafe, ineffective, or experimental/investigational.
b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.

b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

***Basic Medicaid Billing Guide*:** http://www.ncdhhs.gov/dma/medbillcaguide.htm

EPSDT provider page: http://www.ncdhhs.gov/dma/EPSDTprovider.htm

3.0 When the Procedure Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

3.1 General Criteria

Medicaid covers rhinoplasty/septoplasty when it is medically necessary and

a. the procedure is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;

b. the level of service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

c. the service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

Medical necessity will be considered when any of the following conditions are met:

a. Septal deviation causing continuous nasal airway obstruction, resulting in nasal breathing difficulty that does not respond to appropriate medical therapy

b. Deformities of the bony nasal pyramid that directly cause significant and symptomatic airway compromise, sleep apnea, or recurrent or chronic rhinosinusitis when these conditions are not responsive to appropriate medical management

c. Documented recurrent sinusitis felt to be due to a deviated septum and not relieved by appropriate medical and antibiotic therapy

d. Recurrent epistaxis related to a septal deformity

e. Asymptomatic septal deformity that prevents access to other intranasal areas when such access is required to perform medically necessary surgical procedures

f. Deformity secondary to congenital cleft lip and/or palate or other congenital defect of the nose

g. Reconstruction following removal of a nasal malignancy, an abscess, or osteomyelitis that has caused severe deformity and breathing difficulty

h. Significant deformity caused by specifically documented trauma within the previous 18 months

4.0 When the Procedure Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

4.1 General Criteria

Rhinoplasty or septorhinoplasty procedures are not covered when

a. the recipient does not meet the eligibility requirements listed in **Section 2.0;**

b. the recipient does not meet the medical necessity criteria listed in **Section 3.0;**

c. the procedure unnecessarily duplicates another provider's procedure; or

d. the procedure is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria

Rhinoplasty/septoplasty procedures are not covered when they are performed

a. to improve appearance, instead of primarily to restore bodily function or to correct a significant deformity caused by congenital anomaly, injury, disease, or growth and development that resulted in significant functional impairment or disfigurement; or

b. more than 18 months after the documented trauma that caused the significant deformity.

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

5.1 Prior Approval

Prior approval is required for most rhinoplasty procedures.

The following information should be submitted with each prior approval request:

a. Location and cause of the defect/deformity
b. Supporting documentation for the procedure
c. Pre-operative medical photographs of the defect consisting of frontal, lateral, and columellar views
d. Listing of the CPT codes describing the procedures to be performed
e. Documentation of frequency, severity, and description of symptoms
f. Bodily function that will be improved or restored
g. Medical records documenting the history of the trauma or injury (if applicable), with the date of injury and any other related surgeries
h. Documentation of sleep apnea and/or symptoms of breathing obstruction, if applicable, including conservative treatment rendered

6.0 Providers Eligible to Bill for the Procedure

Providers enrolled in the N.C. Medicaid program who perform rhinoplasty/septoplasty may bill for this procedure when it is within the scope of their practice.

7.0 Additional Requirements

7.1 Federal and State Requirements

All providers must comply with all applicable state and federal laws and regulations.

7.2 Records Retention

As a condition of participation, providers are required to keep records necessary to disclose the extent of services rendered to recipients and billed to the N.C. Medicaid program [Social Security Act 1902(a)(27) and 42 CFR 431.107].

Records must be retained for a period of at least five years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations, or agreements (10A NCAC 22F.0107).

Copies of records must be furnished upon request.

The Health Insurance Portability and Accountability Act (HIPAA) does not prohibit the release of records to Medicaid (45 CFR 164.502).

8.0 Policy Implementation and Update Information

Original Effective Date: January 1, 1985

Revision Information:

Date	Section Updated	Change

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity

C. Procedure Codes

The following procedure codes require prior approval.

CPT Code	Description
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)

The following procedure codes do not require prior approval:

CPT Code	Description
21235	Graft; ear cartilage , autogenous, to nose or ear (includes obtaining graft)
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
30540	Repair choanal atresia; intranasal
30545	Repair choanal atresia; transpalatine
30560	Lysis intranasal synechia
30580	Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)
30600	Repair fistula; oronasal
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)
30630	Repair nasal septal perforations

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Place of Service

Inpatient hospital, outpatient hospital, ambulatory surgery center, office, clinic

F. Co-Payments

Recipients do not pay co-payments for rhinoplasty procedures.

G. Reimbursement Rate

Providers must bill their usual and customary charges.